



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 28, 2026

Administrator

BETHANY ON THE LAKE LLC

1020 LARK STREET

ALEXANDRIA, MN 56308

RE: CCN: 245434

Cycle Start Date: September 23, 2026

Dear Administrator:

On September 23, 2026, a survey was completed at your facility by the Minnesota Department(s) of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.

- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" and/or an "E" tag), i.e., the plan of correction should be directed to:

Stacy Line, BSN, RN, Regional Operations Supervisor
Fergus Falls District Office
Health Regulation Division
2312 College way
Fergus Falls, 56537
Email: stacy.line@state.mn.us

Office: 218-332-5159

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by December 23, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 23, 2027 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900

Saint Paul, MN 55164-0900

Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/23/2026		
NAME OF PROVIDER OR SUPPLIER BETHANY ON THE LAKE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET , ALEXANDRIA, Minnesota, 56308				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 9/21/26 to 9/23/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.			E0000			10/06/2026	
F0000	INITIAL COMMENTS On 9/21/26 to 9/23/26, a standard recertification survey (S#5434039-0) was conducted at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.			F0000				10/06/2026
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident			F0580				

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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F0580 SS = D	Continued from page 1 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by:			F0580	Continued from page 1 Blood glucose readings were audited with no other issues identified. All residents who have blood glucose testing have the potential to be affected if this process is not met. All necessary Bethany on the Lake staff have been educated on the process of notifying the provider if the blood glucose reading is greater than 400mg/dL. The DON/designee will audit blood glucose readings greater than 400 mg/dL weekly for four weeks, then monthly for two months to verify that the on-call physician was notified as required by the standing order. Any deficient practices will be identified and corrected at the time of occurrence. Audit findings will be reported to the facility's QAPI committee for review and determination of whether additional interventions are necessary to sustain compliance. Corrective Action will be completed on or before 10/2/2026.		10/06/2026

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F0580 SS = D	Continued from page 2 Based on interview and document review, the facility failed to notify the physician for elevated blood sugar for 1 of 5 residents (R2) who was reviewed for unnecessary medications. Findings Include: R2's admission Minimum Data Set (MDS) dated 6/21/26, identified R2 had severe cognitive impairment with diagnoses which included: Alzheimer's disease, diabetes mellitus and arthritis. R2's MDS identified R2 required substantial maximal assistance with transfers, walking and dressing. R2 received insulin. R2's Care Plan dated 9/22/26, identified R2 had self-care deficit related to compression fracture, diabetes, Alzheimer's, dementia and chronic pain. Assist of one with grooming, dressing and bathing. Nails would be cut by nursing department. Review of R2's Order Summary Report signed 8/26/26, included the following: -blood sugar (BS) checks four times a day (QID) before meals and at bedtime. Treat blood sugars less than 70 per policy, document interventions and outcomes, if no improvements after treatment notify Doctor of Medicine (MD). If BS is greater than 400 notify MD. Review of R2's Weights And Vitals Summary from 6/15/26 to 9/22/26, identified the following Blood Sugar: -9/6/26, at 11:32 a.m.- 419 Review of R2's progress notes from 9/6/26 to 9/22/26, lacked documentation notification was made to the primary care provider for elevated blood sugar over 400 as ordered. During phone interview on 9/22/26 at 1:53 p.m., R2's primary care provider (PCP)-A confirmed her expectation was if a resident's BS was greater than 400, she would be notified, as that was a standard order for insulin. PCP-A stated it was important for her to be notified, because the resident's BS could continue to rise or not respond to the insulin. PCP-A indicated she was not notified R2's BS was greater than 400. During interview on 9/22/26 at 3:51 p.m., registered nurse unit manager (RN)-A confirmed R2's BS on 9/6/26, was elevated, and R2's medical record			F0580			10/06/2026

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F0580 SS = D	Continued from page 3 lacked documentation R2's MD was notified. RN-A stated her expectation was to notify MD if R2's BS was over 400. RN-A indicated it was important to notify MD if a resident's BS was elevated because it needed to be brought down, otherwise the resident could have ill effects from high blood sugars, and they could continue to go higher. During interview on 9/22/26 at 4:05 p.m., director of nursing (DON) indicated their blood sugar policy identified if BS was greater than 400, they were to contact the MD immediately. DON stated this was important to address high BS immediately and get orders for a treatment, such as an insulin order to bring down the BS, or it could contribute to a lot of things. The facility policy titled Blood Glucose Monitoring, undated, identified to notify the practitioner of critical test results within your facility's time frame to ensure prompt treatment. The facility policy titled Notification Of Changes Policy dated 11/25, identified changes in a resident's condition or treatment be shared with the resident and/or the resident representative, according to authority and reported to the attending physician or delegate. Objective of policy included to ensure facility staff made appropriate notification to the physician when there was a change in the resident's condition, or an accident that may require physician intervention. To provide appropriate and timely information about changes relevant to a resident's condition.			F0580			10/06/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions to prevent falls for 1 of 1 residents (R2) investigated			F0689	F689 S/S=D The process for ensuring resident specific fall prevention interventions is in place and implemented according to the plan of care has been reviewed and revised as needed to ensure the process is followed. The required fall mat for resident that was identified was immediately placed when the concern was noted. All residents with fall prevention interventions have been audited to verify interventions are in place as indicated in the plan of care. Staff identified as not implementing the required fall prevention intervention were immediately educated. All residents with identified fall prevention interventions could be affected should the process not be followed. All necessary Bethany on the Lake staff have been educated on the requirement to follow the resident's plan of care and ensure all resident specific fall		10/06/2026

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F0689 SS = D	Continued from page 4 for fall safety. Findings Include: R2's admission Minimum Data Set (MDS) dated 6/21/26, identified R2 had severe cognitive impairment with diagnoses which included: Alzheimer's disease, arthritis, repeated falls and fracture. R2's MDS identified R2 required substantial maximal assistance with transfers, walking and dressing. R2 had one fall with no injury since admission. R2's Care Area Assessment dated 6/24/26, identified R2 was at risk for falls due to history of falls, Alzheimer's disease and R2 did not realize his limitations. R2 was adjusting to new environment. R2 received narcotic and antipsychotic medication which could increase risk for falls. R2 had one fall since admission with no injury. R2 was receiving therapy to improve abilities back to baseline. R2's potential complications were falls and injury. R2's Care Plan dated 9/22/26, identified R2 was at risk for falls related to compression fracture, history of falls, Alzheimer's disease, dementia and chronic pain. R2's interventions included: assist with hour of sleep (HS) cares and to bed at 7:30 p.m., video monitoring, low bed and safety mat, and offering toileting every two hours. The facility form titled Pocket Care Plan-Turtle Beach, undated, identified R2's safety interventions included low bed and safety mat, video monitoring, toilet every two hours, and assist with HS cares and to bed at 7:30 p.m. R2's Fall Review Evaluation form dated 6/15/26, identified R2 was alert and orientated to self, and unable to realize limitations. R2 required assistance of two with Ez-Stand (mechanical lift) for transfers. R2 had standard precautions in place. R2 did not always utilize call light appropriately. During observation on 9/22/26 at 9:21 a.m., R2 was lying in a low bed, covered in bedding with street clothes on and shoes. R2's eyes were closed and his door was open. R2 had a fall mat up against the wall between the bed and wall. R2's beside table was next to the bed. During observation on 9/22/26 at 9:43 a.m., R2 remained lying in a low bed, covered in bedding with street clothes on and shoes. R2's eyes were closed and his door was open. R2's fall mat remained up against the wall between the bed and wall.			F0689	Continued from page 4 prevention interventions are in place and implemented as ordered. The DON/designee will complete weekly audits for four weeks, followed by monthly audits for two months, to verify resident specific fall prevention interventions are present and implemented as indicated in the plan of care. Any identified concerns will be immediately corrected and addressed through staff education and/or corrective action, as appropriate. Audit results will be reviewed through the facility's QAPI process as indicated. Corrective action will be completed on or before 10/6/2026.		10/06/2026

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F0689 SS = D	Continued from page 5 During observation and interview on 9/22/26 at 9:58 a.m., surveyor asked nursing assistant (NA)-A to check on R2. NA-A immediately noted R2's fall mat was not in place while he was in bed, then entered R2's room and placed the fall mat next to the bed. NA-A indicated she thought therapy staff had placed R2 in bed without the fall mat in place. NA-A indicated R2 was at risk for falls, and his fall prevention interventions included fall mat, soft touch call light, gripper socks in bed, a camera in his room and toileting every two hours. NA-A indicated it was important to put his fall mat on the floor while in bed to protect R2. At 10:24 a.m., NA-A informed surveyor that it was therapy staff who had put R2 in bed without the fall mat in place. During interview on 9/22/26 at 3:51 p.m., registered nurse unit manager (RN)-A reviewed R2's last three falls with surveyor and interventions put in place to help prevent falls. RN-A stated NA-A had informed her that R2's fall mat was not in place while in bed. RN-A stated she had educated therapy staff to assure fall interventions were in place. RN-A stated it was important to ensure that fall interventions were in place to prevent further falls, safety and to prevent injuries. RN-A indicated her expectation was for fall interventions to always be in place every day. During interview on 9/22/26 at 4:05 p.m., director of nursing (DON) indicated her expectation was that fall interventions were in place for the residents. DON stated the care plan and the nursing assistant's pocket care plans were updated with new interventions as needed and should be followed. DON indicated interventions were reviewed by the interdisciplinary team and changed as needed. The facility policy titled Fall Prevention And Management revised 11/25, identified Its purpose was to identify residents at risk for falls, implement fall prevention interventions, provide guidelines for assessing a resident after a fall and to assist staff in identifying cause of the fall. The policy identified facility staff would identify interventions related to residents' specific risks and causes to try to prevent the residents from falling and try to minimize complications from falling. Care plans were dated to reflect fall interventions.			F0689			10/06/2026
F0628 SS = A	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation.			F0628			10/06/2026

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F0628 SS = A	Continued from page 6 When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made			F0628			10/06/2026

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F0628 SS = A	Continued from page 7 by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of			F0628			10/06/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 09/23/2026	
NAME OF PROVIDER OR SUPPLIER BETHANY ON THE LAKE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET , ALEXANDRIA, Minnesota, 56308			
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F0628 SS = A	Continued from page 8 Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section.			F0628			10/06/2026

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F0628 SS = A	Continued from page 9 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to send a copy of the notice of discharge to the representative of the Office of the State Long-Term Care (LTC) Ombudsman for 1 of 1 resident (R88) reviewed for discharge. Findings include: R88’s admission Minimum Data Set (MDS) dated 6/26/26, identified R88 was at risk for decreased cognitive and physical abilities related to diagnosis including; Viral Meningitis (swelling of the nerves), Type 1 diabetic, polyneuropathy (nerve pain), Dysphagia (trouble swallowing). Review of R88’s progress notes from 6/26/26 to 6/29/26, identified R88 was admitted on 6/26/26, and left Against Medical Advice (AMA) 6/26/26. R88’s progress notes dated 6/29/26, reported that resident left facility AMA.			F0628			10/06/2026

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F0628 SS = A	Continued from page 10 R88's medical record lacked documentation that a notification of R88's discharge was sent to the LTC ombudsman. During an interview on 09/22/2026 at 2:08 p.m., Administrator verified R88 left AMA from the facility. Administrator verified that ombudsman was not notified of R88's discharge. Administrator stated facility's usual practice was not to notify the ombudsman of AMA due to discharge was not facility initiated. A facility policy titled Ombudsman Hospital Transfer Report August 2025, was provided identified copies of notices for emergency transfer must be sent to the Ombudsman, but they may be sent when practicable, such as in a list of residents on a monthly basis. Policy lacked information regarding residents who leave the facility AMA.			F0628			10/06/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 09/22/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany on the Lake LLC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			10/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245434		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HO... B. WING		(X3) DATE SURVEY COMPLETED 09/22/2026	
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3.Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Bethany Home was originally constructed in 1964 and has gone through several additions and has had one remodel in 2012. Building one, the long and short term care is mainly a two story building. It had a 3 story addition constructed in 2003, with nursing home care on the first level only. The entire structure is of type II (111) construction and the three story section is separated by two 2 hour fire barriers. One located along the assisted living and the other along the south end separating the 2 & 3 story sections. The buildings are fully sprinkled with a monitored fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. Both levels have 2 hour fire barriers separating resident wings, common areas and admin.			K0000			10/06/2026

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K0000 Bldg. 01	Continued from page 2 The facility has a capacity of 83 beds and had a census of 68 at the time of the survey.			K0000			10/06/2026
K0921 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain Patient Care Related Electrical Equipment per NFPA 99 (2012 edition), Health Care Facilities Code. Sections 10.3, 10.5.2, 10.5.2.1.2 and 10.5.6 This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/22/2026 at 9:11 AM, it was revealed by a review of available documentation and staff interview that the facility could not provide documentation			K0921	K-0921 =F Testing and Maintenance-PCREE All Bethany Patient Care Related Electrical Equipment has been tested per NFPA All Bethany Patient Care Related Electrical Equipment will be tested Annually, upon new purchase or as needed per manufactures instructions. Audits of Bethany Patient Care Related Electrical Equipment to ensure compliance will be conducted weekly X4, then Monthly X2 and then Yearly. Results will be provided to Bethany QAPI committee. Maintenance Director is responsible for ensuring compliance moving forward Completion of correction will be 10/6/2026		10/06/2026

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K0921 SS = F Bldg. 01	Continued from page 3 showing that Patient-Care Related Electrical Equipment (PCREE) had been inspected within the last year. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0921			10/06/2026
K0226 SS = E Bldg. 01	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/22/2026 at 10:36 AM, it was revealed by observation that above the ceiling at the 2-hour fire barrier between Darling and Latoka there was an unsealed penetration. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0226	K-0226 =E Horizontal Exits The identified Darling/Latoka unsealed penetration point was repaired with approved Fire Caulk All fire barriers will remain free of unsealed penetration points. Audits of Bethany Fire Barriers to ensure compliance will be conducted weekly X4, then Monthly X2. Results will be provided to Bethany QAPI committee. Maintenance Director is responsible for ensuring compliance moving forward Completion of correction will be 10/6/2026		10/06/2026
K0291 SS = E Bldg. 01	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have a patterned impact on the residents within the facility.			K0291	K-0291 =E Emergency Lighting The identified Battery powered emergency lighting was removed as it was not needed due to entire facility and emergency lighting are on back up generator power. All emergency lighting will be powered by back up generator facility wide Audits of Bethany Emergency Lighting to ensure compliance will be conducted weekly X4, then Monthly X2. Results will be provided to Bethany QAPI committee.		10/06/2026

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K0291 SS = E Bldg. 01	Continued from page 4 Findings include: 1. On 09/22/2026 at 10:05 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested annually for 90 minutes within the last year. 2. On 09/22/2026 at 10:05 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation showing that the emergency lighting in the facility had been tested monthly for 30 seconds within the last year. An interview with the Maintenance Director verified these deficient findings at the time of discovery.			K0291	Continued from page 4 Maintenance Director is responsible for ensuring compliance moving forward Completion of correction will be 10/6/2026		10/06/2026
K0321 SS = E Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms			K0321	K-0321 =E hazardous areas-enclosure The identified Hazardous areas enclosure on Maple Lake was replaced with a new door latch All hazardous enclosures will remain in proper working order and latch when indented. Audits of Bethany Hazardous areas enclosure to ensure compliance will be conducted weekly X4, then Monthly X2. Results will be provided to Bethany QAPI committee. Maintenance Director is responsible for ensuring compliance moving forward Completion of correction will be 10/6/2026		10/06/2026

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K0321 SS = E Bldg. 01	Continued from page 5 (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, and 19.3.2.1.5(5). This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 09/22/2026 at 9:55 AM, it was revealed by observation that door to the soiled utility room in Maple Lake did not positively latch when tested. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0321			10/06/2026
K0920 SS = D Bldg. 01	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA			K0920	K-0920 =D electrical equipment=power cords The identified power extension cord on maple lake was removed from the floor No power extension cords will be utilized on Bethany Campus Audits of Bethany Campus for any power extension cords to ensure compliance will be conducted weekly X4, then Monthly X2. Results will be provided to Bethany QAPI committee. Maintenance Director is responsible for ensuring compliance moving forward Completion of correction will be 10/6/2026		10/06/2026

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K0920 SS = D Bldg. 01	Continued from page 6 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 09/22/2026 at 9:54 AM, it was revealed by observation that an extension cord was being used to power the Arial Computer in Maple Lake. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0920			10/06/2026

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NAME OF PROVIDER OR SUPPLIER BETHANY ON THE LAKE LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1020 LARK STREET , ALEXANDRIA, Minnesota, 56308			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K0000 Bldg. 02	INITIAL COMMENTS FIRE SAFETY An annual Life Safety survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/22/2026. At the time of this survey, Bethany On The Lake was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Building Two, the chapel area, was constructed in 2003 and is one level, type V (111) construction. This building is separated with a 2 hour fire barrier from the main building. Buildings 01 and 02 are fully sprinkled with a monitored fire alarm system. Smoke detectors are located in the corridors, spaces open to the corridors and in the resident rooms. The facility has a capacity of 83 beds and had a census of 68 at time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are MET.			K0000			10/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE